NORTHLAND WOMEN'S HEALTH CARE, P.C.
OBSTETRICS / GYNECOLOGY

PATIENT HISTORY FORM

First Name ____________ MI ___ Last Name ____________ Date of Birth ________

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed

Occupation ____________ Education ____________

History of ☐ Tobacco Use – Current Amount ____________ Years of Use ________

☐ Alcohol Use – Current Amount ____________ ☐ Drug Use – Current Type & Amount ____________

OBSTETRICAL HISTORY

No. of Pregnancies ___ Premature Births <37 wks ___ Miscarriages ___ Abortions ___ Ectopic ___ Living Children ___

BORN (mo/yr)	WEEKS PREG.	WEIGHT lbs/oz	SEX	DLV. TYPE	REMARKS
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________
___ / ___	___	___ / ___	○ M ○ F	○ Vag ○ C-Sec	____________

GYNECOLOGICAL HISTORY

Menstrual History – Age at First Period ___ Age at Menopause ___

Regular periods ○ Yes ○ No Comments ____________

Vaginal Infection / **Sexually Transmitted Infection History**: Please check if you have ever had any of the following:
☐ Chronic Yeast Infections ☐ Trichomonas ☐ Chronic Bacterial Vaginosis ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ Syphilis
☐ Pelvic Inflammatory Disease ☐ Human Papilloma Virus (HPV, Warts) ☐ Other ____________

(If you find any of the Sexual History questions particularly offensive, leave blank and discuss with your Provider)
Sexual History: Have you ever had sex? ○ Yes ○ No Age at first sexual experience ___ Number of lifetime partners ___
Are you currently sexually active? ○ Yes ○ No Do you have sex with ○ males ○ females ○ both

Contraceptive History: Current method ____________ Other methods you have used ____________

Pap Smear History: Date of last Pap Smear ________ Any history of abnormal Pap? ○ Yes ○ No
Please list any treatments you have had for abnormal Paps ____________

Please continue on next page

PAST MEDICAL HISTORY

Please check if you have had any of the following conditions

- ☐ 1. Migraines
- ☐ w/Aura (Neurologic Changes)
- ☐ 2. Heart Disease/Problems
  Type _____
- ☐ 3. High Blood Pressure
- ☐ 4. High Cholesterol
- ☐ 5. Respiratory (Lung) Disease/Problems
  Type _____
- ☐ 6. Asthma
- ☐ 7. Breast Disease/Problems
  Type _____
- ☐ 8. GERD/Reflux
- ☐ 9. Stomach Ulcers
- ☐ 10. Bowel Disease/Problems
  Type _____
- ☐ 11. Kidney Disease/Problems
  Type _____
- ☐ 12. Urinary Incontinence
- ☐ 13. Recurrent/Frequent Urinary Infections
- ☐ 14. Blood Disorders
  Type _____
- ☐ 15. Blood Transfusions
- ☐ 16. Blood Clots - DVT, PE
- ☐ 17. Skin Disease/Problems
  Type _____
- ☐ 18. Thyroid Disorder
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ 19. Diabetes
- ☐ Gestational Diabetes
- ☐ 20. Cancer - _____
  Cancer - _____
- ☐ 21. Epilepsy/Seizures/
- ☐ 22. Neurological Disorders/Problems
  Type _____
- ☐ 23. Arthritis
- ☐ 24. Osteoporosis
- ☐ 25. Autoimmune Disease/Problems
  Type _____
- ☐ 26. Endometriosis
- ☐ 27. Fibroids of Uterus
- ☐ 28. Infertility
- ☐ 29. Uterine/Cervical Abnormality
  Type _____
- ☐ 30. Anxiety
- ☐ 31. Depression
- ☐ 32. Abuse/Domestic Violence
- ☐ 33. Other - _____
  Other - _____

SURGICAL HISTORY

Hospital Admissions/Surgeries (date/reason)

Please continue on next page

FAMILY HISTORY

Please state if each family member is living or deceased, current age or age at death, any major medical problems or cause of death.

FAMILY MEMBER	LIVING-AGE	DECEASED-AGE-CAUSE OF DEATH	MEDICAL PROBLEMS
Mother	○ - ____	○ - ____ - _____	_____
Father	○ - ____	○ - ____ - _____	_____
Mother's Mother	○ - ____	○ - ____ - _____	_____
Mother's Father	○ - ____	○ - ____ - _____	_____
Father's Mother	○ - ____	○ - ____ - _____	_____
Father's Father	○ - ____	○ - ____ - _____	_____
Siblings	○ - ____	○ - ____ - _____	_____
Siblings	○ - ____	○ - ____ - _____	_____
Siblings	○ - ____	○ - ____ - _____	_____
Siblings	○ - ____	○ - ____ - _____	_____
Children	○ - ____	○ - ____ - _____	_____
Children	○ - ____	○ - ____ - _____	_____
Children	○ - ____	○ - ____ - _____	_____
Children	○ - ____	○ - ____ - _____	_____
Children	○ - ____	○ - ____ - _____	_____

Please list known close blood relatives with any of the following problems.

CONDITION	RELATIVE	RELATIVE	RELATIVE	RELATIVE
Breast Cancer	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____
Endometrial/Uterine Cancer	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Heart Disease/Heart Attack	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Blood Disorders/Bleeding Problems	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Twins or Triplets	_____	_____	_____	_____
Congenital, Genetic or Birth Defects	_____	_____	_____	_____

Patient Signature

Date _____

_____

Signature